



Gloucester County Health Department
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MOBILE RETAIL FOOD APPLICATION

☐ **AMENDMENT** ☐ **RENEWAL**

MOBILE VENDOR BUSINESS AND EVENT INFORMATION

Trading Name of Mobile Vendor _____		License Plate # _____	
<input type="checkbox"/> Seasonal	<input type="checkbox"/> Annual	<input type="checkbox"/> Temporary	Name and Date of Event _____
Approval Date of Last Full Application _____			
County/Municipal Health Agency Issuing the Approval _____			
Owner/Corporation _____		Street Address _____	
Mail Address _____		City _____	State _____ Zip _____
Home Phone# _____		Cell# _____	Fax# _____
Email _____	Event Coordinator _____		Phone # _____

CHECK THE BELOW ITEMS WHICH HAVE NOT CHANGED:

- ☐ My **set-up** has *not* changed from my original approved application. NOTE: If the set-up has changed, page one of the original application and the floor plan must be modified and submitted for approval.
- ☐ My **menu** has *not* changed from my original approved application. NOTE: If the menu has changed, page two of the original application must be modified and submitted for approval.
- ☐ My **servicing area** has *not* changed from my original approved application. NOTE: If the servicing area has changed, page three of the original application must be modified, signed and submitted for approval.

I hereby certify that I am familiar with the State law (N.J.A.C. 8:24) requiring that all mobile retail food establishments operate from an approved base location (otherwise known as a “servicing area”) and that all mobile units/vehicles return daily to such location for vehicle and equipment cleaning, discharging liquid or solid wastes, refilling water tanks and ice bins, and boarding food. I also understand that the home preparation and storage of food, or the cleaning of equipment or utensils used in this mobile operation is prohibited and is subject to penalties, fines and possible license forfeiture. AND, I hereby certify that the above listed information is correct.

Mobile Owner/Operator (print) _____	Date _____
Mobile Owner/Operator (signature) _____	
Health Department Inspector (print) _____	Date _____
Health Department Inspector (signature) _____	